Cherry Hospital
Organization ID: 3082
201 Stevens Mill RoadGoldsboro, NC 27530

Accreditation Activity - Evidence of Standards Compliance 1 Form
Due Date: 12/6/2007

HAP Standard PI.1.10 The hospital collects data to monitor its performance.

Surveyor Findings: EP 2 Observed in For-Cause Survey Activity at Cherry Hospital site. The hospital had not done enough to collect data on on staff opinions and needs, staff perceptions of risks and staffs willingness to report unanticipated events. Staff continue to find the need to complain to the Joint Commission when perceptions of issues exist that seem uncomfortable or insurmountable to bring before the organization's leadership. Complaints addressed in this and previous For-Cause surveys were, in some instances, vague but suggested that there were risks to patients and problems with care delivery. The organization's leaders need to be proactive in determining what staff have concerns about. EP 12 Observed in For-Cause Survey Activity at Cherry Hospital site. Although the hospital may have been collecting some information related to the outcome of resuscitative episodes, it did not address the appropriate management of some patients for whom intervention was not appropriate as identified by CMS site review. Changes in approaches to medical emergencies were implemented within the last six to eleven months prior to this survey. Clearly the organization should have had better data collection to identify problems with systems for managing medical emergencies.

Elements of Performance:

2. The hospital considers collecting data in the following areas: Staff opinions and needs Staff perceptions of risks to individuals and suggestions for improving patient safety Staff willingness to report unanticipated adverse events

Scoring Category: B

Corrective Action Taken: EP2.B - In response to the Requirement for Improvement cited by Joint Commission, the hospital has implemented several strategies to improve communication between the employees and organizational leadership. A Cherry Hospital Communication Line was implemented in which employees can call a designated telephone number to report a concern, issue, or ask a question. Messages can be left anonymously. Suggestion Boxes were placed in eight locations across campus to encourage employees to communicate concerns to leadership. Messages left on the Cherry Hospital Communication Line and in the Suggestion Boxes are retrieved by the Assistant Hospital Director and forwarded to the Hospital Director. The concerns, issues, and questions are then assigned to a member of the Senior Leadership Team for review, with instructions to provide a written response to the Hospital Director within 7 calendar days. If the employee has requested a response, the Hospital Director provides written follow-up to the employee within 10 days of receipt of the suggestion or concern. On a monthly basis, the

Assistant Hospital Director will provide a report to the Senior Leadership Team regarding the number of communications received via the Communication Line and Suggestion Boxes. Each concern/question and the response will be reviewed by Senior Leadership to determine if trends exist and to validate that appropriate action has been taken to address the question/concern. A summary of answers to frequently asked questions/concerns with Hospital-wide impact will be posted on the hospital's intranet site and in the hospital newsletter. Other strategies which will be implemented by December 5, 2007 include Senior Leadership conducting rounds at least quarterly, Senior Leadership conducting "Town Hall Meetings" for all employees, and implementation of a monthly Brown Bag Lunch meeting with the Hospital Director.

12. The hospital collects data that measure the performance of each of the following potentially high-risk processes, when provided: Resuscitation and its outcomes.

Scoring Category: A

Corrective Action Taken: EP 12.A - The hospital had processes in place at the time of the survey for the collection of data regarding resuscitation and its outcomes. The PI Department audits 100% of cases in which resuscitation is required. A report of resuscitation outcomes is provided quarterly to the Executive Leadership Team at Cherry Hospital via the Performance Improvement Quarterly Report. In September 2007, a review of processes related to medical emergencies was conducted. The Director of Nursing issued a directive to all staff regarding their roles and responsibilities during medical emergencies. In addition, in September 2007 all RNs were required to complete a nursing competency in Medical Emergencies/Code Blue procedures. Effective December 2007, the PI Department will provide a monthly report to the Hospital Director, Clinical Director and Director of Nursing regarding outcomes with all medical emergencies.

HAP Standard PI.2.30 **Processes for identifying and managing sentinel events are defined and implemented.**

Surveyor Findings: EP 5 Observed in For-Cause Survey Activity at Cherry Hospital site. In the review of files of employees terminated for cause, one was identified of an employee who had been accused of Rape of a patient with continued sexual contact with the patient when the patient was discharged from the hospital. Although subsequent investigation yielded an admission on the part of the patient that it was consensual, this constituted a Sentinel Event at the time that the employee was terminated and the established process for conducting a Root Cause Analysis should have been conducted. The event occurred in July of 2006, the accusation was made against the employee in June of 2007. Additionally, this did constitute a near miss that warranted evaluation to assure that a similar, more serious event be averted.

Elements of Performance:

5. The processes are implemented.

Scoring Category: B

Clarification Documentation: CLARIFICATION RESPONSE Cherry Hospital had processes for identifying and managing sentinel events in place at the time of the survey. A policy was in effect which defined Sentinel Events and Near Misses, as well as the procedures for initiating a Root Cause Analysis. This policy, and a RCA that had been conducted for an earlier Sentinel Event, were shared with the surveyor as evidence that processes for managing Sentinel Events were in effect at Cherry Hospital. The situation referenced in this citation did not meet the Joint Commission's definition of a Sentinel Event and therefore, a Root Cause Analysis was not warranted. On June 7, 2007, a patient reported that she was raped by a staff member during a hospitalization one year earlier at this facility. The patient's allegation met the criteria defined in our Abuse, Neglect, Exploitation policy and an investigation was immediately initiated through our Advocacy Department and Cherry Hospital Police Department. Upon interview by the Police Officer on June 8, 2007, the patient recanted the allegation of rape. The investigation confirmed acknowledgments by the female patient and the male employee that they engaged in a consensual sexual relationship which began after the patient's discharge. Both parties denied that any sexual contact had occurred on the premises of Cherry Hospital. At the time of the employee's dismissal, the investigation had concluded that the sexual relationship was consensual and did not occur while the patient was hospitalized. According to Joint Commission, rape is considered a Sentinel Event if it meets the following definition: "rape as a reviewable sentinel event, is defined as unconsented sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital ...". Based on the facts obtained through an investigation of this allegation, there was no occurrence which is subject to review by Joint Commission as a Sentinel Event. BECAUSE OF THE HOSPITAL'S COMMITTMENT TO CONTINIOUS QUALITY IMPROVEMENT, WE WILL USE THE CITATION AS AN OPPORTUNITY FOR IMPROVEMENT AS FOLLOWS: All direct care staff will review the Sentinel Event/Near Miss Policy (CCP, VI-S-5). Staff members will be reminded of the requirement to complete a Sentinel Event/Near Miss Notification Form for all identified sentinel events and near misses. The notification form is to be submitted to the Performance Improvement Department immediately upon identification of a sentinel event or near miss. The Performance Improvement Department will validate, through Staff Development Training Records, that all staff have reviewed the policy by January 30, 2008.

HAP Standard PC.12.40 **The initial assessment of each patient at admission or intake assists in obtaining information about the patient that could help minimize the use of restraint or seclusion.**

Surveyor Findings: EP 10 Observed in For-Cause Survey Activity at Cherry Hospital site. An Advance Directive with respect to behavioral health care was not separately discussed or documented in the open records of two patient tracers conducted including that of an

adolescent girl with multiple episodes of restraint. An additional two open records of patients who had been restrained multiple times were also reviewed.

Elements of Performance:

10. The hospital determines whether the patient has an advance directive with respect to behavioral health care and ensures that direct care staff is aware of the behavioral health advance directive.

Scoring Category: A

Corrective Action Taken: At the time of the survey, the hospital had a policy in place to determine if a patient had any type of advance directive, including an Advance Instruction for Mental Health Treatment, as defined by North Carolina General Statutes 122 C 71-77. In accordance with NCGS 122C 71-77, Cherry Hospital's policy applies to individuals considered legal adults, who are ages 18 and over. An Advance Instruction for Mental Health Treatment would not have been applicable with regard to the situation referenced in the Surveyor Findings, involving the open record of the "adolescent girl". Therefore, the corrective action, referenced in this document, will apply only to adult patients (ages 18 or over) who are hospitalized at Cherry Hospital. In response to the Requirement for Improvement cited by Joint Commission, the Director of Nursing, Clinical Director and Social Work Supervisor will send a directive to their staff members by November 30, 2007 to clarify the Advance Directive process. Upon admission, the RN will assess if the patient has an advance directive and record this information on the Patient Information/Advance Directives form. If this information cannot be obtained upon admission due to the patient's mental status, the status of the advance directive will be determined at the Treatment Team Meeting conducted within 10 days of admission or at the time of discharge, whichever comes first. For patients with a guardian, the assigned Social Worker will send a request for advance directive information to the designated guardian within 5 days of admission. Advance directive information will also be assessed by the screening team upon transfer of patients from one unit to another. On a daily basis, the status of each patient's advance directive information will be reviewed during the morning interdisciplinary report (board review). Follow-up by the RN will occur on a daily basis for any patient, identified during morning report, who has not completed the Patient Information/Advance Directives form. The Clinical Director will send a directive to direct care staff members by November 30, 2007 regarding the requirement to discuss the status of advance directives during the morning report. The Medical Records Department will conduct an audit of 50 charts monthly x 4 months to verify the presence of advance directive information.

HAP Standard PC.12.60 **Restraint or seclusion is limited to emergencies in which there is an imminent risk of a patient physically harming himself or herself, staff, or others, and non-physical interventions would not be effective.**

Surveyor EP 2 Observed in For-Cause Survey Activity at Cherry Hospital site. Information from the

Findings: patient's initial assessment did not appear to influence the type of physical intervention selected. When a patient's behavior constituted a danger to self, other patients and/or staff, the patient was placed in "Four-Point" restraints. A Therapeutic hold, to bring the patient to restraint was also routinely conducted. The organization stated that there was no capacity to address other measures such as seclusion. Additionally, information from the patient's psychosocial information such as sexual abuse history did not play into decisions to restrain the patient in Four-Points. Observed in For Cause Survey Activity at Cherry Hospital site. As above, initial assessment information did not influence the methods of physical restraint for this patient traced who had multiple episodes of restraints. Four-point restraints were the only method used. Observed in For-Cause Survey Activity at Cherry Hospital site. As above, initial assessment information did not influence the methods of physical restraint for this patient whose open chart was reviewed as part of this survey and for whom there were multiple episodes of restraints. Four-point restraints were the only method used.

Elements of Performance:

2. The type of physical intervention selected considers information learned from the patient's initial assessment.

Scoring Category: C

Corrective Action Taken: The Evaluation for Admission Form was revised by the Clinical Director to include a more comprehensive assessment of special considerations related to restrictive interventions. The revised form will be approved by November 30, 2007 and implemented by December 10, 2007. The debriefing section of the Restrictive Intervention Progress Note Form was revised by the Assistant Director of Nursing to allow staff to document responses from the debriefing that could be used to assist care givers in the reduction of restrictive interventions for the patient. The new Restrictive Intervention Progress Note Form will be implemented by December 10, 2007. A process will be implemented by December 10, 2007 in which the results of the Level 1 Debriefing conducted by the RN and the Level 11 Debriefing conducted by Psychology will be discussed during the interdisciplinary morning report. The Clinical Director will issue a directive by November 30, 2007 instructing staff members to include the debriefing information in the morning report, effective December 10, 2007. Information from the debriefing that would be helpful in reducing further restrictive interventions will be documented on the patient's kardex under a section entitled "Special Considerations for Restraint/Seclusion". Training of staff regarding the kardex process will occur in December 2007 and implementation of the process will occur by January 15, 2008. The Performance Improvement Department will conduct an audit of 50 kardexes per month x 4 months to verify the completion of the "Special Considerations" section.

Evaluation Method: a. Training of staff regarding the kardex process will occur in December 2007 and implementation of the process will occur by January 15, 2008. One hundred percent (100%) of target staff will have been trained by implementation date. b. The Performance Improvement Department will conduct an audit of 50 kardexes per month x 4 months to verify the completion of the "Special Considerations" section. Ninty percent (90%) of all kardexes reviewed will indicate completion of special consideration section within 4 months.

Measure of Success Goal (%): 90

HAP Standard PC.12.160 **The patient and staff participate in a debriefing about the restraint or seclusion episode.**

Surveyor Findings: EP 4 Observed in For-Cause Survey Activity at Cherry Hospital site. The organization had developed a form for the express purpose of documenting the debriefing of patients and staff after a restraint episode. However, the form serves as a reminder to he issues to be included in the discussion but does not serve as a tool to document the responses from the debriefing that would assist the care givers in the reduction of restraint episodes for the patient. Additionally, since the organization only employs one method of physical restriction, the patient's preferences and concerns with Four-Point restraint were not addressed. Three open records were reviewed as part of tracer activity conducted during this For-Cause Survey.

Elements of Performance:

4. Information obtained and documented from debriefings is used in performance improvement activities.

Scoring Category: B

Corrective Action Taken: The debriefing section of the Restrictive Intervention Progress Note Form was revised by the Assistant Director of Nursing to allow staff to document responses from the debriefing that could be used to assist care givers in the reduction of restrictive interventions for the patient. The new Restrictive Intervention Progress Note Form will be implemented by December 10, 2007. A process will be implemented by December 10, 2007 in which the results of the Level 1 Debriefing conducted by the RN and the Level 11 Debriefing conducted by Psychology will be discussed during the interdisciplinary morning report. The Clinical Director will issue a directive by November 30, 2007 instructing staff members to include the debriefing information in the morning report, effective December 10, 2007. Information from the debriefing that would be helpful in reducing further restrictive interventions will be documented on the patient's kardex under a section entitled "Special Considerations for Restraint/Seclusion". Training of staff regarding the kardex process will occur in December 2007 and implementation of the process will occur by January 15, 2008. The Performance Improvement Department will audit 100% of the restrictive interventions x 4 months to validate that debriefing was conducted.